

**REPORT TO THE PBC Governance  
TO BE HELD ON: 8<sup>th</sup> July 2009**

<b>Enclosure:</b>					
<b>Subject:</b>	Prescribing Incentive Scheme South East Staffs Consortium				
<b>Lead Director:</b>	Sue Price				
<b>Lead Officer:</b>	Dr V Rajput				
<b>Recommendation:</b>	For Approval	X	For Discussion		For Information

**PURPOSE OF THE REPORT:**

This report presents a proposal from South East Staffs Consortium to develop a local prescribing incentive scheme

**KEY POINTS:**

The scheme is additional to and builds on the Quality and Outcomes guidance for prescribing. This scheme aims to incentivise more cost effective, quality prescribing. It will ensure increased involvement of practices within practice based commissioning and provide a resource, if savings are made, to invest in practices.

**CORPORATE OBJECTIVES:**

1. Demonstrate good financial management
2. WCC objective -Promotes and specifies continuous improvements in quality and outcomes through clinical and provider innovation and configuration

**RESPONSIBLE COMMITTEE:**

NAME:

APPROVED at cmte: YES/NO

Date of Cmte:

**IMPLICATIONS:**

<b>Legal and/or Risk</b>	
<b>Standards for Better Health</b>	
<b>Financial</b>	£40,000 for payment to practices which will be recouped from savings if they are realised.  Potential savings from more cost effective prescribing will be shared between the PCT and practices
<b>Training</b>	
<b>PBC</b>	Submitted by PBC
<b>Patient Engagement &amp; safety</b>	

**RECOMMENDATIONS / ACTION REQUIRED:**

<b>The committee are asked to: Approve the proposal</b>
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**PRESCRIBING INCENTIVE SCHEME FOR SOUTH EAST STAFFS CONSORTIUM**  
**(SESC) 2009-10**

**BACKGROUND**

Practice Based Commissioning (PBC) supports and enables primary care teams to assess health needs, plan services and secure delivery of care for patients within the practice. Through greater clinical freedom in primary care, it presents an opportunity to innovate and redesign care pathways and services in primary and community care settings as well as improve management of finite resources. It is also an opportunity to enable control over budgets with potential for savings, re-investment and an opportunity to improve quality.

The principles relating to incentives is well established by the Department of Health through its example of using the Quality and Outcomes Framework(QOF). The document; **QMAS Bulletin. NHS Npfit-GMS Payments Project version 2.1(2004)**, states,

*“The QOF provides substantial financial rewards to practices for the provision of high quality care. This will benefit both patients and the NHS.”*

*“Reward and Recognition for Good Practice. PCTs should note that the core philosophy underpinning the QOF is that incentives are the best method of resourcing work, driving up standards and recognising achievement.” “addresses resourcing and rewarding good practice”*

**The Quality and Outcomes Framework Guidance for GMS contract 2009/10** has a medicines management component and Medicines 6 indicator states *“The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing”*. Four points which attracts funding are achieved for meeting this indicator..

The SESC prescribing scheme is additional and builds on the principles in the QOF guidance.

Practices need to agree with the principle of shared responsibility. The way we practice as individuals and as practices has a large impact on our budget and subsequently the “value for money” we get out of a shared budget.

If prescribing savings are generated in this financial year the PCT and health economy will benefit ultimately through delivering improved patient services.

A document from the South Staffs PCT entitled **“Cost Improvement Areas for Primary Care Prescribing- 2009/10”** explained that, *“It is widely recognised that efficient and cost-effective prescribing is good for patient care as any savings realised are available for further healthcare provision. This document reviews the potential areas in which prescribing savings are available, some are simple switches, whereas others are more complex and may require support for safe and effective implementation. Practice based commissioners both within consortia and independent should consider incorporating these savings proposals into their business plans, if they wish to retain any of the savings as “freed up resources”. PBC consortia may wish to agree a “corporate” view on prioritising and achieving the savings made.”* This document involved looking at low cost statins, PPIs, renin angiotensine drugs, generic prescribing and brand prescribing. For addressing just these areas of prescribing the total savings objective was £1,040,700 for South Staffordshire PCT.

While some targets, if achieved, should save money, there are others that will increase costs but should be encouraged as they will improve patient care and reflect current evidence.

Prescribing Incentive Schemes have been used in the locality in the past, both to improve the quality of prescribing as well as well as to encourage cost effective prescribing in line with current evidence and best practice.

## **PROPOSAL**

To establish a Prescribing Incentive Scheme within the SESC

### **AIMS**

- Incentivise more cost effective prescribing
- Incentivise better quality prescribing
- Provide practices with a resource to fund improvement in services
- Through all this illustrate the link between individual clinical behaviour (prescribing), budget implications (whether or not savings are made) and the opportunity this provides to invest in new services.

### **PRINCIPLES**

- The scheme will have both a quality and a savings element to it
- The quality element will be funded “upfront” and will be resourced regardless of total SESC prescribing savings made. However; first call on any total SESC prescribing savings achieved will be to fund this quality element of the scheme.
- The first £100.000 of savings made on the allocated prescribing budget will be available to the Prescribing Incentive Scheme. Any savings above this will be allocated 50% to the Prescribing Incentive Scheme and 50% to the SESC/PCT

The criteria for use of practice allocated prescribing savings will be determined by the SESC but is likely to be encompass use for practice specific requirements and/or rules relating to the use of freed up resources (FURs)

### **COSTS**

- We wish to “guarantee” the funding of the quality element of the scheme, which will have a value of approximately £40.000
- However; the first call on any SESC prescribing savings made will be to fund the quality target
- Once the £40.000 target has been reached, the scheme will be self funding
- A proportion (50%) of any saving above £100.000 will go to the SESC/PCT

### **BENEFITS**

#### To patients

- Quality prescribing initiatives implemented
- Additional resources available to practices for patient care

#### To the PCT/ SESC

- Potential for achievement of savings
- Quality of prescribing/ care will be improved
- Increased practice involvement in PBC

- Opportunity to “pilot” of the use of incentive schemes
- Potential for “innovative” use of resources

#### To the practices

- Opportunity to improve the quality of prescribing with support of resources made available to practices to enable prescribing reviews and implementation of changes
- Additional resources for use within the practice for patient care.

### **IMPLEMENTATION**

Establish the total prescribing budget for the SESC for 2009-10

Define the 2009-10 prescribing budget for each practice (based on Astro PU and adjustments, eg if a practice has a significant number of nursing home patients)

Establish specific practice based quality prescribing objectives for 2009-10 which will attract specific funding for individual practices meeting those objectives.

Agree when prescribing savings would be available and for what purpose it can be used

### **CRITERIA**

This PIS has both a quality and a savings element to it, with further details as follows

Criteria 1 – ALL practices can qualify for the quality element of the scheme

By meeting the agreed prescribing quality objectives (details outlined in Appendix 1) each practice can earn 5 pence per practice Astro PU.

Criteria 2 – (Appendix 5) The additional savings element of the Prescribing Incentive Scheme will be available to practices if the following criteria are met;

- 1) There are overall savings in the SESC prescribing budget
- 2) Individual practice make a saving on either their uplifted prescribing budget for 2009-10 (this budget has already been sent to all practices) or on their historic budget
  - A practice that **UNDERSPENDS** its 2009-10 budget will get an agreed proportion of savings from the total SESC prescribing budget savings. The exact proportion will be dependent on a range of factors, but we anticipate to be able to make 30-40% of savings made available to individual practices
  - A practice that **OVERSPENDS** its 2009-10 budget but **MAKES A SAVING** on its previous 2008-09 historical budget will get a proportion of SESC budget savings. This will be determined on the savings made by the practice and the final allocation determined by the SESC.
  - A practice that **OVERSPENDS** its 2009-10 budget and **DOES NOT MAKE A SAVING** on its previous 2008-09 historical budget will **NOT** qualify for this criterium

## **FINANCE**

This agreement is to cover the 12 months commencing 1<sup>st</sup> April 2009.

Practices will receive:

- Criteria 1 - prescribing savings in recognition of achievement in meeting specific SESC agreed objectives for 2009-10(Appendix 1)
- Criteria 2 – prescribing savings dependant on total SESC prescribing budget savings for 2009-10, individual practice prescribing spend for 2009-10 and prescribing allocation (Appendix 5)
- No payment if Criteria 1 or Criteria 2 not met

**SIGNATURE SHEET**

Practice Stamp:

**PRACTICE BASED COMMISSIONING PRESCRIBING INCENTIVE SCHEME FOR SESC 2009-10**

This document constitutes the agreement between the practice and the SESC

The practice needs to sign and to agree to the following as set out in this protocol.

**Signature on behalf of the Practice:**

Signature	Name	Date	Job Title/Position

**Signature on behalf of the SESC:**

Signature	Name	Date	Job Title

The agreement is to cover the 12 months commencing 1st April 2009.

**PAYMENT WILL ONLY BE MADE UPON RECEIPT OF PRACTICE SIGNATURE SHEET**

**Appendix 1 Quality Targets (Criteria 1)****Specific prescribing quality objectives**

In April 2009 the number of cost-based ASTROPU for South East Staffs Consortium was 791,409.

An ASTRO-PU is an age, sex, and temporary resident originated prescribing unit

A list of individual practice ASTROPUs at April 2009.

<b>Prescriber Name</b>	<b>Total Cost based Astro PUs</b>
ANCHOR MEDICAL PRACTICE	11,400
DR WHARTON'S SURGERY	24,620
CHASETOWN MEDICAL CENTRE	13,065
CLOISTERS MEDICAL PRACT.	58,283
CROWN MEDICAL PRACTICE	24,611
DR AHMAD'S SURGERY	13,891
DR KHARE'S SURGERY	10,150
DR VIJE'S SURGERY	8,505
DR YANNAMANI'S SURGERY	7,726
FAZELEY SURGERY	13,404
HEATHVIEW MEDICAL CENTRE	11,180
HOLLIES PRACTICE	95,417
LAUREL HOUSE SURGERY	81,472
RIVERSIDE SURGERY	10,854
SALTERS MEADOW HEALTH CTR	90,613
SPRINGHILL MEDICAL CENTRE	5,527
THE ALDERGATE MED.PRACT.	76,720
THE LANGTON MEDICAL GROUP	58,727
THE MINSTER PRACTICE	14,029
THE PEEL MEDICAL PRACTICE	62,241

THE SPIRES PRACTICE	57,258
WILNECOTE SURGERY	41,717
	<b>791,409</b>

The consortium has set aside £40,000 for a Local Enhanced Scheme on prescribing.

There will be one Consortium-wide target around antibiotic prescribing and two practice-based targets. Practices will be notified about their practice-based targets

### **Prescribing for Antibiotics**

#### Rationale

GP prescribing of antibiotics in SStaffs PCT is the highest in the West Midlands, and 9% above the national average. Inappropriate antibiotic prescribing contributes to the increase in C-Diff and MRSA infections.

The following information for practices to follow is attached

- Appendix 2. Details of the leaflets, posters and handouts that can be obtained from the Department of Health
- Appendix 3 The pages on respiratory tract infections extracted from the primary care antibiotic prescribing formulary 2007.
- Appendix 4 The summary flowchart NICE Guidance on Antibiotic prescribing

#### Audit

Practices will undertake an audit of all antibiotic prescribing for a one week period. The findings of this audit will be presented at a practice meeting by a member of the practice (this is expected to be a prescriber) who will also discuss the NICE Guidance on respiratory tract infections, the local antibiotic formulary on RTI and their implementation. The meeting will be facilitated by a practice pharmacist or the local senior pharmaceutical adviser. The practice will be asked to present an action plan agreed by all prescribers on how they will implement the NICE guidance, including a delayed antibiotic prescription policy if this is felt appropriate.

Payment 5p per ASTRO PU

**Appendix 2: Antibiotic prescribing (leaflets)**

February 2008



**Get well soon – without antibiotics**

**Order Form**

Product Title	Product Code	Maximum order quantity	Copies required
Get well soon without antibiotics (leaflet)	284682	200	
Poster 1 – Hand	290980	200	
Poster 2 - Cloud	290982	200	
Poster 3 – Goal	290981	200	
Get well soon - Non-prescription pad	290508	50	

Delivery details:

Name: \_\_\_\_\_  
 Job Title/Role: \_\_\_\_\_  
 Organisation: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Postcode: \_\_\_\_\_ Tel: \_\_\_\_\_  
 Email: \_\_\_\_\_

You can either order online at [www.orderline.dh.gov.uk](http://www.orderline.dh.gov.uk), complete this order form and fax it to: 01623 724 524, post it to DH Publications Orderline, PO Box 777, London SE1 6XH. Alternately you can e-mail your order to: [dh@prolog.uk.com](mailto:dh@prolog.uk.com), or you can contact the DH Publications Orderline by phoning 0300 123 1002.

Please allow 10 days for delivery. Orders will only be fulfilled once all the materials are available.

### **Appendix 3: Antibiotic prescribing (Extract from the Primary Care Antibiotic Formulary 2007)**

#### **LOWER RESPIRATORY TRACT INFECTIONS**

##### **Cough & Other Lower Respiratory Tract Infections**

After patients with chronic lung disease or clinically suspected pneumonia are excluded, antibiotics provide little or no benefit for patients with cough and lower respiratory tract symptoms, including fever and green sputum. Regardless of treatment method, cough will last about three weeks in most patients and for at least a month in 25%. Patients given an immediate prescription for an antibiotic are more likely to expect antibiotics in the future. Providing a verbal explanation about the expected course and potential complications of cough during the consultation is most likely to assure optimal patient satisfaction (3).

##### **Acute Bronchitis**

###### **Almost always viral.**

Routine antibiotic use is not warranted in otherwise healthy patients with cough and purulent sputum.

Antibiotic therapy should be considered in the following groups

- Reduced resistance to infection.
- Co-existing illness, diabetes, congestive heart failure, asthma, COPD
- History of previous persistent mucopurulent cough
- Clinical deterioration.

###### First Line

**Amoxicillin** 500mg three times a day for 5 days

###### Second Line

**Doxycycline** 200mg on the first day then 100mg daily for 5 days

## **Pneumonia**

The British Thoracic Society defines pneumonia as :-

- Symptoms of an acute LRT illness (cough and at least one other LRT symptom).
- New focal chest signs on examination.
- At least one systemic feature (either a symptom complex of sweating, fevers, shivers, aches and pains and / or temp of 38C or more).
- No other explanation for the illness which is treated as Community Acquired Pneumonia with antibiotics

First Line

**Amoxicillin** Capsules 500mg 8hrly for 7 days

For suspected atypical pneumonia or penicillin allergy:

**Clarithromycin** 500mg every 12 hours for 7-14 days

## **Acute Exacerbations of COPD**

First Line

**Amoxicillin** 500mg three times a day for 5 days

Second Line

**Doxycycline** 200mg on the first day then 100mg daily for 5 days or

**Co-Amoxiclav** Tablets 500/125mg three times a day for 5 days

## **NOTES**

1. Erythromycin is of doubtful efficacy against *Haemophilus influenzae*, Clarithromycin has better activity against *Haemophilus influenzae*
2. In chronic bronchitis, the colour of purulent sputum may take some time to resolve because of the time taken for inflammation to resolve. If the patient continues to be ill, consider a change in antibacterial agent, preferably after bacteriological investigation.
3. Tetracyclines - avoid in children and pregnancy - caution in elderly if renal impairment suspected.
4. Erythromycin and clarithromycin are active against *Mycoplasma pneumoniae*, *Chlamydia pneumoniae* and *Legionella pneumophila*. Tetracyclines are active against *Mycoplasma* but not *Legionella*.
5. Clarithromycin is favoured as first choice macrolide due to a lower incidence of GI side effects and increased blood levels.

## UPPER RESPIRATORY TRACT INFECTIONS

Not giving antibiotic prescriptions for sore throats reduces re-attendance rates (2).

### Pharyngitis/Sore Throat/Tonsillitis

Most are viral and self limiting. If a decision to prescribe an antibiotic is made then treat with:

**Phenoxymethylpenicillin** Tablets 500mg four times a day for 10 days.

If the patient is allergic to penicillin use:

**Clarithromycin** 250-500mg twice a day for 5 days.

### **Sinusitis**

Most are viral. Reserve antibiotics for severe or persistent symptoms.

**Amoxicillin** 250-500mg every eight hours for 5 days

Penicillin allergy: **Clarithromycin** 500mg 12 hrly for 5 days

### Acute Otitis Media

Reviews considering the use of antibiotics in otitis media suggest either selective use in severe cases or shared decision making with the parent (7,8,9). In children with otitis media but without fever and/or vomiting, antibiotic treatment has little benefit (10). Deferred prescriptions and the use of information leaflets have proved to be very successful in reducing the number of prescriptions dispensed (9).

If bacterial infection is suspected:

**Amoxicillin** 500mg every 8 hours for five days

Treatment failures: **Co-amoxiclav** dose according to BNF

If allergic to penicillin

**Clarithromycin** 250mg every 12 hours for 5 days

1. Do not use amoxicillin if glandular fever is suspected.
2. Avoid topical aminoglycoside antibiotic eardrops if perforation of ear-drum.
3. For alternatives in acute otitis media see acute bronchitis.

## References

(2) Antibiotics for acute bronchitis T Fahey, J Smucny, L Becker, R Glazier Cochrane Database of Systematic Reviews Date of Most Recent Substantive Amendment: 25 August 2004

(3) Little P, Rumsby K, Kelly J, et al. Information leaflet and antibiotic prescribing strategies for acute lower respiratory tract infection. A randomised controlled trial. JAMA 2005;293: 3029-35.

(7) Antibiotics for Acute Otitis Media, Glasziou PP et al. Cochrane Database Of Systematic Reviews

(8) Diagnosis and Management of Childhood Otitis Media in Primary Care SIGN Guideline No. 66 February 2003

(9) Cates C An evidence based approach to reducing antibiotic use in children with otitis media: controlled before and after study. BMJ 1999;318:715-6

(10) Little P et al. BMJ 2002 325 22 Predictors of poor outcome and benefits from antibiotics in children with acute otitis media: pragmatic randomised trial.

## Appendix 5: Quality targets (criteria 2)

### Practice-based Targets

Practices will be **given two practice specific targets** by the Senior Locality Pharmaceutical Adviser from the following list below.

Payment for achieving each target will be 1.5p per ASTRO PU.

#### **NSAIDS**

##### Rationale

There are significant safety issues associated with the use of all oral NSAIDs which include an increased risk of heart failure, renal failure and GI bleeds. In addition, the coxibs and diclofenac have been shown to increase cardiovascular risk.

##### Target

The cost of oral NSAIDs/1000 STARPU should not exceed the National average. For practices above the National Target a reduction of 10% or more is required (this will be measured Feb to March 2010. The baseline is Feb to March 2009). **In addition**, prescribing for ibuprofen and naproxen items should account for 60% of all NSAID items.

#### **Screening and monitoring agents**

##### Rationale

Local guidance has been produced by the Staffordshire diabetes network ([Appendix 6](#)). Practices should aim to work towards this guidance. NICE Guidance advocates the use of Blood Glucose Monitoring Strips only as part of a structured education programme. The PCT cost-based endocrine per 1000 STAR PUs (sex, therapeutic area, age related prescribing unit) is £57 for February and March 2009.

##### Target

For the expenditure on screening and monitoring strips not to exceed £57 per 1000 cost based endocrine STAR-PU. For practices above national average a target reduction in costs of 10% (Measured Feb – Mar 2010 inc) is required.

#### **Prescribing of Drugs acting on the Renin-angiotensin system**

##### Rationale

NICE Guidance for hypertension, heart failure and diabetes all recommend that if a drug acting on the renin-angiotensin system is appropriate, ACE inhibitors are first line treatment. ACE inhibitors have superior evidence base in terms of improved outcomes over AIIIRA's. The NHS Institute for Innovation and Improvement publishes a "Better Care, Better Value" indicator that measures the percentage of prescription items for ACE Inhibitors in relation to the total number of prescription items for drugs affecting the renin-angiotensin system, excluding combination preparations. The Strategic Health Authority target is at least 77% of

drugs prescribed for the renin-angiotensin system are prescribed as ACE inhibitors. The National Prescribing Centre have published supporting information including audit templates and Standing Operating Procedures ([www.npci.org.uk/nsm](http://www.npci.org.uk/nsm))

#### Target

The proportion of ACE inhibitors to be no less than 77% of all drugs acting on the rennin-angiotensin system. For practices less than 77%, a target of 5% increase of the proportion of ace inhibitors from March 2009 is required (measured Mar 10)

#### **Prescribing of opioid patches**

##### Rationale

Transdermal analgesia costs are growing exponentially; there is significant variation between practices. Transdermal analgesia should be generally reserved for patients with swallowing difficulties or intolerance issues with oral morphine.

##### Target

An audit of all prescribing of transdermal patches, followed by an action plan regarding the appropriateness of prescribing.

